2002

MEDICAL BOARD OF CALIFORNIA

Strategic Plan 2002

november 2002

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STRATEGIC PLAN 2002

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Introduction

Of all of the professions licensed by the State of California, physicians and other health professionals have the most direct measurable impact on the quality of life, health and welfare of Californians. Each day, millions of California residents and visitors rely on the integrity and accuracy of the licensing and regulatory systems administered by the Medical Board of California (MBC). These systems ensure that people are receiving healthcare by physicians and allied health professionals who have been judged to be qualified to provide it.

Established in 1876, the Board is one of the oldest regulatory boards in the state, and is primarily supported by fees from licensees. The Board is self-funded and receives no money from the State's General Fund. The mission of the Medical Board of California is to protect consumers through proper licensing of physicians and affiliated healing arts professions and through the vigorous, objective enforcement of the Medical Practice Act.

The Medical Board of California is a state government agency, which licenses and regulates medical doctors and other affiliated healing arts professions. The Board provides two principal types of services to consumers: public-record information about California-licensed physicians, and investigation of complaints against physicians.

MBC is one of the boards, bureaus, commissions and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services agency, which performs its functions under the aegis of the Governor. DCA is responsible for consumer protection and representation through the regulation of licensed professions and the provision of consumer services. While the DCA provides administrative oversight and support services, MBC sets its own policies, procedures and regulations.

Board membership of MBC is mandated by statute. Seventeen of the nineteen (twelve physicians and five public members) are gubernatorial appointees. Based on recommendations coming out of the Sunset Review Committee, Board membership was recently expanded by two public members, both of whom are assigned to the Division of Medical Quality. The remaining two public members are appointed by the Speaker of the Assembly and the Senate Rules Committee, respectively.

Board members are assigned to one of two Divisions – the Division of Medical Quality and the Division of Licensing. In addition, each Board member is encouraged to serve on at least one Board committee.

Periodically the State Legislature requires that a Joint Legislative Sunset Review Committee (JLSRC) be convened to review the need for and ongoing viability of each special Board and Commission at the State level. The JLSRC also provided an overview of the Board's activities, achievements and problems since the last Sunset Review. In May 2002, the JLSRC

published a series of findings, many of which have been incorporated into the strategic planning process. These included recommendations for: appointment of an Independent Enforcement Monitor; improvements to complaint processing; disclosure policy improvements and increasing the Board by two public members. The JLSRC further concluded that:

> Continued regulation of the profession is critical and consumers must be able to rely upon appropriate regulatory oversight of this profession to ensure that practicing physicians and surgeons are well trained and maintain a license in good standing, and that physicians are held accountable if they do not provide appropriate healthcare and treatment for their patients. For this reason, the Board should be closely monitored over the next few years by both the JLSRC and the Department to assure it is fulfilling its consumer protection mission.

Background on Strategic Planning

The mandate and mission of the Medical Board of California is clear – to protect the public. In the legislative oversight arena, the mandate is the standard by which the Board is judged. With California's diverse and growing population, carrying out the mandate within limited resources is a challenge. The Board must balance the need for in-depth investigation with the need to move expeditiously to discipline and remove from practice health practitioners who pose a danger to the public. At the same time, the Board has a requirement to educate and inform consumers. A strategic plan helps to focus the Board's activities by reviewing the Board's functions, identifying areas for improvement and generating an action plan.

The last Strategic Plan was prepared in response to Department of Finance requirements. Adopted by the Board in 1997, this plan presented a mission, vision, goals, activities, objectives, strategies and critical success factors for the Board. Many of the initiatives identified in the 1997 Strategic Plan have been implemented. Others have not, either due to resource limitations or changes in legislative or administrative priorities.

Recent Accomplishments

Since the last Strategic Plan, MBC accomplishments and improvements have included:

- Decrease in the time required to complete investigations and file an accusation.
- Increase in partnerships, access and information to benefit consumers.
- Continued improvement in the administration and user-friendliness of the licensing process, including on-line availability of basic application and renewal processes.
- Improvement of enforcement times via the DIDO program, where investigators work one-on-one with the Attorney General's Office.

- Improved Board composition, with more public membership and esprit de corps, with enthusiastic involvement in committee assignments.
- Adoption of successful legislative initiatives, including educational loan repayment for physicians willing to undertake indigent care.
- Resolution and adoption of a Public Disclosure Initiative and plan of action.
- Implementation of a nationally and internationally recognized Diversion Program with a 71% success rate.
- Addition of a Medical Director to the Medical Board, increasing MBC's ability to put science into decisions.
- Initiation of a data collection system by the Information Systems Branch to evaluate policies, programs and processes.
- Adoption of an expert reviewer program allowing the Board to do neutral and objective case review.

Overview of 2002 Strategic Plan Process

The Board established a Strategic Planning Subcommittee in late 2001. In October 2001, and August 2002, the Strategic Plan Subcommittee articulated issues for potential discussion in the strategic planning process. Issues identified in 2001 included:

- Indigent Care;
- Uniformity and Consistency of Licensing and Disciplinary Processes;
- Prediction and Intervention of Practitioner Problems;
- Assessment of the Usefulness of Certified Medical Experts (CMEs) in Fostering Quality Care;
- Board Oversight of Licensing and Disciplinary Process; and
- License Portability and Offshore Medical Schools.

Additional issues identified for discussion at the August 2002 Board meeting were:

- Public Education;
- Diversion Program;
- Physician Recognition Program; and
- Allied Health Practitioner Oversight.

The initiatives identified by the JLSRC in 2002 also provided material for consideration in the Strategic Planning process, especially those related to enforcement, complaint processing and disclosure.

A management planning session was held in July 2002. At this planning session, management staff of MBC discussed success factors, goal areas and stakeholder expectations for the strategic planning process. Constituents to be interviewed for the Environmental Scan were identified, along with questions and issues to be discussed in the interviews.

In preparation for the Board's Strategic Planning Meeting in September 2002, a total of 22 constituents were interviewed. The results of these interviews were synopsized and used to further define strategic issues to be discussed by the Board in the strategic planning process. These findings are incorporated in the Environmental Scan Summary (Appendix B).

Strategic Issues

While discussing the external environment, a number of issues were identified by MBC in the areas of qualifications, discipline, access to care, physician shortages, professional limitations presented by managed care, malpractice, quality of oversight and review and consumer information. MBC recognizes that these broader issues are interrelated and require attention. MBC has identified six specific key issues facing the organization:

- Continued competency
- Enforcement program reform
- Consumer awareness
- Access to care
- Partnership opportunities
- Organizational resource limitations

Additional improvements were discussed under an umbrella category, which is labeled Practice Improvements.

In discussing and developing strategies and actions, MBC determined the details of each issue and methods by which to address each of them.

Continued Competency

Licensing program workload increased nearly 15% during the three years between the 1998 and 2001 Sunset Reviews. The increase in number of applications, growth in problematic applications and staff turnover has placed significant stresses on staff. While re-engineering improvements to the licensing process made in 2001 have improved functioning, issues around licensing and professional qualifications remain a key area needing development of strategy. Among the states, the State of California has some of the most stringent and complex licensing requirements for physicians. The challenge is to maintain high standards while ensuring a continuing supply of physicians to meet the growing needs of California's population. For example, currently, foreign medical school graduates must have two years of post-graduate training compared to only one for U.S. and Canadian graduates. However, with no discrepancy in disciplinary rates between these two groups, the question is whether this requirement is justified. There is also the issue of how to best address the accreditation of offshore medical schools, ensuring supply of physicians while maintaining quality.

The growth in alternative medicine has led to concerns about how to balance patient choice with patient protection while also eliminating the fear of discipline among some physicians who are practicing safe and effective alternative medicine.

Continuing medical education has long been viewed as the primary instrument for achieving continued physician competency. However, there are limited data to support the efficacy of

this approach. Other methods for ensuring continued competency such as required re-certification and peer review might have more merit.

The Diversion Program is nationally recognized as being effective. However, there is question as to whether an alternative administrative structure – perhaps outside of the Medical Board – is more appropriate.

Enforcement Program Reform

The Medical Board needs to be able to respond quickly, disciplining and revoking licenses of physicians who present a threat to the public. Recently, a report was completed outlining issues and potential actions for enforcement program reform. These included changes in practices and procedures for investigations, expert review, legislation, the Division of Medical Quality, the Attorney General's office, and Administrative Law Judges. While implementing the full program requires the hiring of more investigators, the Board will also outline what can be accomplished within the existing framework. Other key regulatory and enforcement issues and needs include:

- Quality-related and ethical issues presented by increased use of cosmetic procedures and telemedicine.
- Use of new technologies to create an early warning system for identifying "problem" physicians.
- Data to address allegations that the Board discriminates in areas of enforcement and discipline and guidelines to ensure uniformity of discipline across ethnicity and practice areas.
- Monitoring and filling gaps in disclosure provisions in SB1950.
- Appropriateness and capacity for Board enforcement of other allied professions.

Consumer Awareness

The Medical Board is one of the most important yet least-understood agencies serving the public. The public needs to have easy-to-access information available in a variety of formats. While MBC is self-funded through licensing fees, state-imposed limitations on budget limits the resources available for public education. Increasingly, consumers have access to information through the Internet, resulting in more sophistication and higher expectations from consumers about the quality and ease of information access. The MBC Web site can be an effective tool – the issue is the depth and detail of information to be included, along with ease of use. A Communications Plan is being prepared that addresses audiences, information needs and techniques for providing public information. Also, there is the opportunity to make increased use of partnerships with allied organizations and agencies and to expand dissemination of information on Board initiatives and programs.

Access to Care

Cost of care is a growing barrier, especially for indigent populations. The population of California's medically uninsured is growing and has now reached over seven million. In addition, rationing of care and inadequate reimbursement for managed care can further limit access to critical medical services. While this is not a direct statutory responsibility of the Medical Board, the Medical Board recognizes the need to influence the process, especially at the legislative level. Alliances and partnerships can be formed with those who have similar objectives. There is also the ability to influence through incentives and licensing initiatives. A Board position paper could define the crisis and present access to care as an issue of major societal importance. The paper could include a statement on access to care, the practical implications and what the Board can do in alliance with others and on its own through incentives, recognition and leverage.

Partnership Opportunities

It is important that the Medical Board be collaborative. Other organizations that are aligned with the Board's core mission can be engaged in productive partnerships. The Board needs to pursue open communications with a common language, especially with related organizations such as the Center for Public Interest Law (CPIL) and the California Medical Association (CMA). The Board needs to consider its relationship to emerging professional groups through Board education and speakers and decide which relationships are true professional alliances. Joint legislative initiatives among MBC, CMA, and consumer organizations can further build relationships; trauma care is an example of a potential common issue. Implementing actions in the Strategic Communications Plan in light of Strategic Plan priorities can help further alignment.

Organizational Resource Limitations

The most significant challenges to MBC organizational effectiveness concern resource limitations, antiquated data systems, and the current staffing classification system. Even though MBC is funded through special fees, in the area of resource management, MBC is affected by policies instituted by the State to deal with General Fund shortfalls. Given this reality, priority setting is key. The hiring freeze and retirement "enhancement" programs are specific challenges for MBC. Staffing and resource limitations require a Strategic Plan that identifies clear goals, along with realistic timing and priorities for achieving the goals. Priorities should reflect MBC's core mission – that is, the extent to which an improvement will allow the Board to license, regulate, and discipline physicians.

Delivery and administration of MBC initiatives and information systems is challenged by "legacy" data systems – the DCA data system is 19 years old. Given the level of sophistication needed for public education and management tools, this system presents significant barriers for MBC. The system is slated for upgrade but this will require five years and a $13-20 million investment. Therefore, strategies for improved systems should be both strategic and incremental. The process includes:

- Determining performance needed from the DCA system,

- Working with DCA to upgrade the data system,
- Improving work flow within MBC to allow better use of current systems, and
- Addressing and removing potential barriers to system improvements.

A final resource limitation influencing organizational effectiveness is the staff classification system. The system is a barrier to hiring and is not responsive to market conditions. A complete review of staff compensation and classification is needed.

Practice Improvements

Practices of those who are involved in investigation, review or adjudication of disciplinary actions can have a serious – and negative – effect on meeting the mission to protect the public. For example, there are no established standards of practice for expert witnesses in malpractice, personal injury, and workers' compensation cases. The Industrial Medicine Council (IMC) oversees workers' compensation and Qualified Medical Expert (QME) certification. Qualification for QME is largely based on administrative skill rather than medical expertise. One immediate option is to reaffirm the AMA position (and get a supporting Attorney General opinion) that being an expert witness constitutes the practice of medicine and requires proper certification and proper ethics.

The Medical Board has the opportunity to change the perception that MBC is solely a "policing" board. There is a need for an MBC recognition program that is focused on those who improve access and reduce the gaps, and provides for group as well as individual recognition.

MBC Strategic Plan Framework

A Strategic Plan Framework has been created, containing the following elements:

- Mission
- Vision
- Goals
- Major Constituencies
- Action Plan

A. Mission

The mission of the Medical Board of California is to protect healthcare consumers through proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

B. Vision

Our vision for healthcare in California is:

- Access to high-quality medical care;
- Educated and informed consumers who have choices for healthcare and know how to make these choices for themselves and their families;
- A continuing supply of highly qualified physicians supported by other healthcare professionals and paraprofessionals, all of whom are committed to quality, access and integrity in healthcare;
- Effective partnerships with all major medical, healthcare enforcement organizations and consumers which serve to enforce standards of quality, access and consumer protection; and
- Fair, timely and effective enforcement of all laws related to the practice of medicine.

C. Goals

The Medical Board has established five goals. These goals provide the framework for the results it wants to achieve in furtherance of its mission.

PROFESSIONAL QUALIFICATIONS
Ensure the professional qualifications of medical practitioners by setting requirements for education, experience and examinations

REGULATIONS AND ENFORCEMENT
Protect the public by (1) preventing violations and (2) effectively enforcing laws and standards when violations occur

CONSUMER EDUCATION
Increase public awareness of MBC's mission, activities and services

ORGANIZATIONAL RELATIONSHIPS
Improve effectiveness of relationships with related organizations to further MBC's mission and goals

ORGANIZATIONAL EFFECTIVENESS
Enhance organizational effectiveness and systems to improve service to constituents

D. Major Constituencies

The Medical Board of California has various constituents who expect the following:

INDIVIDUALS

Constituent Group	Constituent Needs
Licensee Candidates	Ease of process Clarity Simplicity Fast turnaround
Licensees	Guidance Interpretation of new laws and regulations Prompt renewal
Consumers	Action on complaints Information on ▪ Decisions ▪ Enforcement actions ▪ Physician records ▪ Personal medical records
Employers	Information on physicians Expedited licensing

GROUPS AND ORGANIZATIONS

Constituent Group	Constituent Needs
Board Members	Quick, direct action Education on system workings and performance
Local Agency Law Enforcement/ District Attorney	Information Guidance Case help
Legislators and Elected Officials	Resolution Satisfied constituents Advance personal initiative areas
Media	Information Interviews

Action Plan

An Action Plan to carry out MBC's Mission and Goals is presented on the following pages. The Action Plan is organized by Goal. Each section describes (1) Ongoing Responsibilities and (2) Objectives. Lead responsibility is identified for both Ongoing Responsibilities and Objectives. Each of the Objectives also has an assigned target date.

Professional Qualifications

GOAL: Ensure the professional qualifications of medical practitioners by setting requirements for education, experience and examinations

Ongoing Responsibilities	Lead Responsibility
Improve and expedite the review process	Division of Licensing
Determine future Board handling of alternative medicine: appropriate use, balance, licensing and Board responsibilities (such as new boards)	Non-Conventional Medicine Committee
Identify physicians who would benefit from rehabilitation and provide options. Develop a pilot program to implement	Diversion Committee/Division of Medical Quality

Objectives		Lead Responsibility	Target Date
PQ1	Research and bring back a recommendation on accreditation of off-shore medical schools that provides for periodic review and revisiting of certification and ensures continuing quality of offshore-educated physicians practicing in California	Re-certification Committee	January 2003
PQ2	Review eligibility requirements and uniformity of licensing between U.S. and foreign schools to match requirements with quality control	Division of Licensing	April 2003
PQ3	Explore ways to achieve continued competency and report on options, including augmenting or replacing continuing education requirements with peer reviews or competency recertification	Re-certification Committee	July 2004
PQ4	Outline a course of action for dealing with standards of practice for expert witnesses, including: ▪ Identification of issues and problems ▪ Optional solutions ▪ Potential course of action	Division of Medical Quality	January 2004
PQ5	Design and implement a physician recognition program focused on both individual and group recognition of those who improve access and fill gaps in the medical system	Physician Recognition Committee	March 2003

Regulations and Enforcement

GOAL: Protect the public by (1) preventing violations and (2) effectively enforcing laws and standards when violations occur

Ongoing Responsibilities	Lead Responsibility
Monitor and implement SB 1950 (Complaint Disclosure)	Public Education Committee/ Division of Licensing/ Enforcement Committee
Assess status of allied professional certification and explore capacity and options	Enforcement Committee/ Division of Licensing

Objectives		Lead Responsibility	Target Date
RE1	Appoint an Enforcement Monitor	Enforcement Committee	March 2003
RE2	Assemble data for Board discussion to determine validity of issues, correct any differential practices and communicate results to the public and licensees	Enforcement Committee (data collection) Public Education Committee (communication)	November 2002
RE3	Reform the enforcement program to expedite reviews and investigation and to improve the quality and consistency of expert reviews and legal rulings	Enforcement Committee	November 2003
RE4	Complete and implement revision of the Disciplinary Guidelines to improve timeliness, quality and uniformity of discipline	Division of Medical Quality	November 2003
RE5	Explore establishing an early warning system to provide for early identification of problem physicians through monitoring, technology and partnerships for inspection	Enforcement Committee	November 2003
RE6	Examine, assess and monitor the Diversion Program and determine potential new options including location of program administration to ensure confidentiality and confidence in the system	Diversion Committee	January 2004
RE7	Consider new potential legislation on complaint disclosure to augment SB 1950 and fill gaps	Executive Committee	January 2004

Consumer Education

GOAL: Increase public awareness of MBC mission, activities and services

Ongoing Responsibilities	Lead Responsibility
Expand the use of the Web site to communicate with consumers and licensees	Public Education Committee
Use existing communication channels to improve legally mandated reporting and outreach on MBC programs and improvements	Public Education Committee
Utilize the Board as a speakers' bureau to communicate MBC initiatives to constituencies	Public Education Committee
Use medical consultants as a communications tool for MBC initiatives and programs	Public Education Committee

Objectives		Lead Responsibility	Target Date
CE1	Develop a strategic communications plan to increase public awareness of MBC, how to use information and services and initiatives for improvement. Implement plan with key measures and annual review and evaluation system.	Public Education Committee	May 2003

Organizational Relationships

GOAL: Improve effectiveness of relationships with related organizations to further MBC mission and goals

Ongoing Responsibilities	Lead Responsibility
Work with collateral organizations to advocate improved access to quality care for all Californians	Executive Committee
Pursue open communications with related organizations such as the California Medical Association (CMA) and the Center for Public Interest Law (CPIL), including a common language, common understanding of issues and joint legislative strategies	Executive Committee/Public Education Committee
Align relationship-building activities with communication plan priorities	Public Education Committee

Objectives		Lead Responsibility	Target Date
OR1	Identify collateral organizations and strengthen relationships, including the following: CMA, CPIL, the Healthcare Association (HCA), the Office of Administrative Hearings and Hearing Officers (OAH) and the Department of Consumer Affairs (DCA)	Executive Committee	June 2003
OR2	Develop a position paper on the crisis in access to medical care, outlining issues and potential courses of action	Executive Committee	June 2003
OR3	Identify creative approaches to access to care for action and follow-up by the Board	Executive Committee	January 2005

Organizational Effectiveness

GOAL: Enhance organizational effectiveness and systems to improve service to constituents

Ongoing Responsibilities	Lead Responsibility
Provide the Board with a financial overview of source and use of funds and methods for leveraging resources	Staff
Work with other organizations to accomplish the MBC agenda	Staff

Objectives		Lead Responsibility	Target Date
OE1	Set priorities based on MBC's core mission to emphasize protection of the public	Executive Committee	June 2003/ Ongoing
OE2	Work with DCA and its departments to upgrade information technology systems to provide the level of sophistication needed to meet public information needs and manage licensing, enforcement and discipline	Staff	2007
OE3	Address potential business system improvements to meet consumer information and system management needs in the interim	Staff	April 2003
OE4	Review investigative staff compensation and align with market conditions	Executive Committee	June 2003

Performance Measures

The following are Performance Measures that have been identified to track progress under each Goal Area. Desired Outcomes describe the ultimate results envisioned under each Goal Area. The Performance Indicators are designed to directly or indirectly measure progress toward the Desired Outcomes.

PROFESSIONAL QUALIFICATIONS

GOAL: Ensure the professional qualifications of medical practitioners by setting requirements for education, experience and examinations

Desired Outcome	Performance Indicator
Reduction in physicians with practice deficits that have or could lead to patient injuries	REPORTING MEASURES ▪ Percentage of successful diversion program cases ▪ Percentage of quality of care cases resulting in removal of a physician causing or potentially causing patient injury from practice ▪ Number of physicians undergoing compulsory physical and psychological competency exams under Section 820 TRACKING INDICATORS ▪ Number of currently active licensed California physicians participating in the diversion program
Reduced risk of the Board licensing unqualified physicians	TRACKING INDICATORS ▪ Number of applicants granted restricted or probationary licenses ▪ Number of applicants denied licenses or withdrawing from the licensure process

REGULATIONS AND ENFORCEMENT

GOAL: Protect the public by (1) preventing violations and (2) effectively enforcing laws and standards when violations occur

Desired Outcome	Performance Indicator[1]
Quality of care cases resolved quickly and accurately	REPORTING MEASURES ▪ Percent of quality of care accusations that are upheld ▪ Average time to complete an investigation ▪ Average resolution time for cases resulting in removal of a physician causing or potentially causing patient injury from practice TRACKING INDICATORS ▪ Percent of complaints that result in accusations or disciplinary actions

CONSUMER EDUCATION

GOAL: Increase public awareness of MBC's mission, activities and services

Desired Outcome	Performance Indicator
Patients are able to make informed decisions about medical practitioners and unlicensed practitioners and know how to seek remedies through accessible information provided by the Medical Board	REPORTING MEASURES ▪ Number of media and consumer outreach activities ▪ Number of hits to the MBC Web site ▪ Number of calls to the Complaint Unit ▪ Number of calls to the Consumer Information Unit ▪ Number of non-jurisdictional complaints received ▪ Level of complainant satisfaction with MBC response

[1] Note: these measures are pending refinement by the Enforcement Committee. The SB 1950 definition ("resulting in serious injury or death") is operative

ORGANIZATIONAL RELATIONSHIPS

GOAL: Improve effectiveness of relationships with related organizations to further MBC mission and goals

Desired Outcome	Performance Indicator
MBC initiatives and programs promoted through effective relationships and alliances with partner organizations and agencies.	REPORTING MEASURES ▪ Number of legislative initiatives approved by the Board with the assistance of partner agencies TRACKING INDICATORS ▪ Number of organizational relationships resulting in collaborative activities and ventures

ORGANIZATIONAL EFFECTIVENESS

Goal: Enhance organizational effectiveness and systems to improve service to constituents

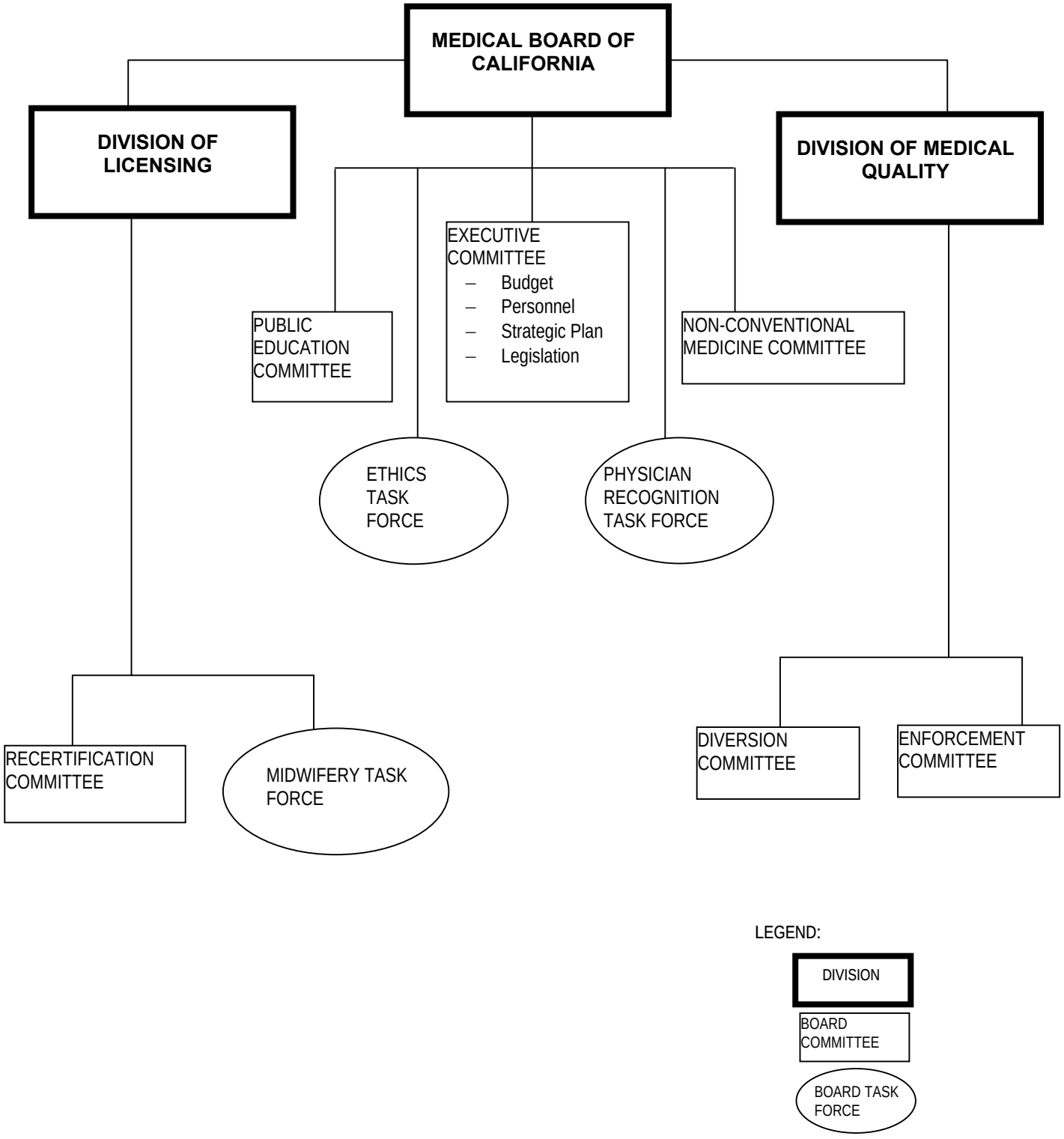
Desired Outcome	Performance Indicator
Ability of MBC to achieve its mission through effective and efficient use of revenue and staff resources to support priority initiatives and programs	REPORTING MEASURES ▪ Percentage of staff indicating job satisfaction through the annual survey ▪ Percentage of staff remaining employed with the MBC – retention rate TRACKING INDICATORS ▪ Percentage of time data and systems are available to staff when needed ▪ Average ticket resolution completed on time

Appendices

- Organizational Chart
- Environmental Scan Summary

Organizational Structure

MBC has developed the organizational structure below to implement its strategic plan.



ENVIRONMENTAL SCAN

EXTERNAL FACTORS INFLUENCING MEDICAL BOARD OF CALIFORNIA

Every update of the Board's strategic plan is preceded by an environmental scan. From an examination of the MBC's external environment, Board members and staff identify the potential issues and challenges that may affect MBC's ability to carry out its mission over the long term. The following trends and assumptions help form the foundation of MBC's strategic plan.

PATIENT CARE

- Increasing depersonalization:

  There is a loss of personal relationships between patients and physicians, which results in dissatisfaction among physicians and patients.
- Continuing lack of access:

  More people need services but resources are increasingly limited. Population increases, immigration, and natural growth combined with declining economic resources create barriers in access to healthcare. There is question as to whether access to healthcare is a "right."
- Changing demographics:

  The graying and coloring of the population. Population increase means that the equivalent of two cities the size of Los Angeles will be added to the California population.
- Declining numbers of nurses and physicians:

  This is "access" on the other side. The physician and nursing population is declining. We need to make sure that we are not inadvertently losing perfectly capable physicians for minor transgressions. The length of the disciplinary process can lead to resignations.

MEDICAL INDUSTRY

- Increasing number of "movements":

  There are a number of trends, including pain management, alternative medicine, and end of life care. The Board needs to evaluate its potential role in these areas.
- Ongoing proliferation of alternative medicine:

  This raises questions of oversight and discipline. Who does it? What is the relationship of the Medical Board to these evolving professions?
- Continuing movement of medicine from hospital to outpatient:

  This raises issues with patient safety. How do we protect the patient? It seems to be by early intervention – at medical school, during certification and during practice.
- Emerging trend toward "lucrative procedures":

There is a trend for physicians to gravitate toward lucrative procedures. Some of these physicians may not have the proper training.

- Increasing scarcity of experts:

  There are issues with recruitment, training, and ability of experts. The enforcement reorganization document coming out will address this.

GOVERNMENTAL AND LEGAL TRENDS

- Continuing State fiscal crisis:

  State budgetary shortfalls have created a hiring freeze, loss of staff and demands to do more with less, despite the fact that the Medical Board is self-funded.

- Decreasing legislative tenure:

  As a result of term-limits, the Medical Board must periodically invest time and resources to educate incoming legislators on Board policies and program operations.

- Increasing lobbyist influence.

  Drug industry lobbying leads to fast track approval of medicines – a regulatory issue.

- Decline in function of the medical legal system:

  The legal profession, not necessarily science, drives decisions. There is need to ensure quality of testimony of expert plaintiff's witnesses. There is a lack of science in medical consultant work and worker's compensation. Excessive settlements increase the cost of practice, which tends to drive physicians out of business.

TECHNOLOGY, MEDICAL ADVANCES, ECONOMIC CHANGES

- Increasing consumer information demands:

  The information age presents increasing consumer sophistication and demand. This places more requirements on the Board for information.

- Ongoing changes to formularies and pharmacy practices:

  New needs are no longer covered. A lack of generics for certain conditions means that medicine is not available to meet needs.

- Emerging technology:

  Increased use of the Internet and increase in non-trained staff dispensing Internet advice can impact patient safety. In addition new technology presents oversight challenges – insulin pumps, micro processing, scanners and lasers, to name a few.

- Increasing globalization:

  Patients are going elsewhere for drugs and traveling beyond the U.S. borders.